Horizon Blue Cross Blue Shield of New Jersey

Small Employer Group Application Instructions

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Horizon Blue Cross Blue Shield of New Jersey Sales Representative.
Please complete all necessary forms in their entirety. Please print in ink or type your responses.

Ensure that all areas requiring a **signature and date are complete.** The Officer, Partner, Owner and / or Correspondent signing the application must be listed on the New Jersey Small Employer Certification.

Completed enrollment application forms should be sent to your authorized Broker or Horizon BCBSNJ Sales Representative **prior to your effective date.**

Documents Included

Attached you will find the forms that must be completed and submitted for each New Jersey small employer group applying for standard health insurance coverage:

- Application for a Small Employer Health Benefits Policy.
- New Jersey Small Employer Certification.
- Small Employer Health Benefits Waiver of Coverage – One form is needed for each employee waiving or refusing coverage. This form may be photocopied as needed.

Other Required Documents

In addition to the forms listed above, **depending on group size / composition and preferred payment method, the following items may also be required:**

- Payroll verification through appropriate tax documentation, i.e., WR30 (required for groups of five or fewer eligible).
- Owner payroll documentation (K-1, Schedule C and/or 1120).
- Automatic Pay Plan Application (#8977).

When submitting your paperwork as required above, **you must also submit the following:**

- Enrollment Change / Request Form (#6803) – One form is needed for each employee enrolling. Your authorized Broker or Horizon BCBSNJ Sales Representative will provide these forms.
- First month's premium – All new cases must be submitted with a company check for the first month's premium payable to Horizon BCBSNJ. If a case is submitted without a premium check, the case will be returned.
- Prior / Current Carrier's most recent billing statement – Required if replacing group medical coverage.
- Rate Quote – The rate quote generated for the group should match the product(s) selected in Section II of the Application for a Small Employer Health Benefits Policy.

Rate Quotes

The rate quote is an estimate based on information provided by your authorized Broker or Horizon BCBSNJ Sales Representative. If there is inaccurate or missing information on the original quote, the rate may change based on an official review of the paperwork submitted to Horizon BCBSNJ.

Submission of Application to Horizon BCBSNJ

Your authorized Broker will submit this Application to Horizon BCBSNJ.

Horizon Blue Cross Blue Shield of New Jersey

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please print or type Policy Number: _____ ☐ New Policy ☐ Change in Policy Requested Effective Date: _____

Note: The Effective Date will be on or after the date Horizon Blue Cross Blue Shield of New Jersey approves the application.

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____

2. Tax Identification Number: _____

3. Main Address: _____
   Street City State ZIP

   Mailing Address: _____
   Street City State ZIP

   Telephone: _____ Facsimile: _____ Email Address: _____

   Contract information should be provided: ☐ electronically or ☐ hard copy. Check one.

4. Correspondent: _____ Title: _____

5. Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): _____

6. Nature of Business (specify): _____ SIC Code: _____

7. Number of full-time employees in your company: _____
   Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

8. Number of full-time employees to be insured: _____ 9. Class or classes to be excluded: _____

10. Insurance Requested For:
    ☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse

    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
    If yes, should the plan provide coverage for coverage of children of a covered domestic partner? ☐ Yes ☐ No

11. Is the employer subject to the requirements of COBRA? ☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? ☐ Yes ☐ No
    Due to disability? ☐ Yes ☐ No

13. Orientation Period? ☐ Yes ☐ No

14. Waiting period before employees become insured: (may not exceed 90 days)
    Present Employees : ☐ no waiting period ☐ one month ☐ two months ☐ 90 days
    New or Rehired Employees: ☐ no waiting period ☐ one month ☐ two months ☐ 90 days

15. Period for Annual Employee Open Enrollment Period: _____

16. What percentage of the premium will the employer pay? _____

17. Deposit $ _____

Premium Paid: ☐ Monthly ☐ Automatic checking withdrawal
Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. of full-time employees in this company	No. of full-time employees to be insured

SECTION II: SPECIFICATIONS FOR COVERAGE

Please select desired health benefits option and stand alone pediatric dental option.

HEALTH BENEFITS

Advantage Direct Access

☐ Platinum 100/70 - $20/$40 copay, $10/$25/$50 Rx, with Blue Card

☐ Gold 100/80/60 - $20/$40 copay, $15/$40/$75 Rx, with Blue Card

Advantage EPO

☐ Gold 100% - $25/$45 copay, $25/$50/$75 Rx
☐ with Blue Card ☐ without Blue Card

☐ Gold 100% - $30/$50 copay, $15/60%/50% Rx
☐ with Blue Card ☐ without Blue Card

☐ Gold 100/80 - $20/$40 copay, $10/$25/$50 Rx
☐ with Blue Card ☐ without Blue Card

☐ Silver 100/70 - $30/$50 copay, $25/$50/$75 Rx
☐ with Blue Card ☐ without Blue Card

☐ Silver 100/50 - $30/$50 copay, $15/50%/50% Rx
☐ with Blue Card ☐ without Blue Card

OMNIA

☐ OMNIA Platinum, $5/90%/70%/70% Rx, without Blue Card
☐ OMNIA Gold, $10/60%/50%/50% Rx, without Blue Card
☐ OMNIA Silver, $15/50% after Tier 1 deductible/50% after Tier 1 deductible Rx, without Blue Card

HSA plans

☐ OMNIA Silver HSA, Tier 1 deductible & 60% Rx, without Blue Card
☐ OMNIA Bronze HSA, Tier 1 deductible & 50% Rx, without Blue Card
☐ HSA Advantage Direct Access Silver 100/80/60 - $30/$50 copay, 60% CDHRx, with Blue Card
☐ HSA Advantage EPO Bronze 100% - $30/50 copay, 50% CDHRx
☐ with Blue Card ☐ without Blue Card

☐ **Other:** _____

STAND ALONE PEDIATRIC DENTAL

☐ Horizon Young Grins (only provides benefits for members under age 19)
☐ Horizon Family Grins
☐ Horizon Family Grins Plus

STAND ALONE PEDIATRIC DENTAL OPTIONS

The Patient Protection and Affordable Care Act (PPACA) permits plans outside of the Small Employer Business Health Options (SHOP) Program to issue coverage without pediatric dental benefits only if reasonably assured that the applicant has purchased an exchange-certified stand-alone dental plan (SAPD) covering the pediatric dental benefits as required by PPACA. In order to receive reasonable assurance from you, we require the following information if you did not select a Stand Alone Pediatric Dental Plan listed above:

☐ Proof of coverage or other documentation reasonably acceptable to the Health Insurance Issuers evidencing your enrollment in an exchange certified SAPD. Proof acceptable may be a copy of enrollment confirmation from the SAPD issuer or a copy of your coverage document (for example, a certificate of coverage).

☐ The contact information of your SAPD issuer that we may verify your enrollment with, which you expressly grant our ability to verify your enrollment:

Name of SAPD Issuer: _____

Policy Number: _____

Name of Contract Holder: _____

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and name of insurance carrier(s):_____

   _____

2. Name of present or prior group carrier: _____

   Effective date of prior coverage: _____ Cancellation/termination date: _____

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "Yes", give reason _____

   Plan being replaced: _____

3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

4. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	Continuation Dates End

If additional space is needed, attach a separate sheet, signed and dated.

5. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

_____

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

SECTION IV: AGENT/PRODUCER INFORMATION AND UNDERWRITING GROUP ENROLLMENT USE

Agent Producer Information (This information must be answered completely)

BROKER SIGNATURE ____________ DATE ____________ VENDOR NUMBER ____________

BROKER-NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

SUB-PRODUCER INFORMATION AND COMMISSION SPLIT

Sub-Producer Information (This information must be answered completely)

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________%
Sub-Producer Commission Percentage

SUB-PRODUCER SIGNATURE | DATE | NPN NUMBER

SUB-PRODUCER NAME | NAME OF AGENCY | TELEPHONE NUMBER

STREET | CITY | STATE | ZIP CODE

____________%
Sub-Producer Commission Percentage

SPECIAL INSTRUCTIONS

For Internal Underwriting Use

☐ Approved for _____ Number of Subscribers _____

☐ Declined

Underwritten By _____ Date _____

For Internal Group Enrollment Use

	ADV DA	ADV EPO	OMNIA	HSA ADV DA	HSA ADV EPO	OMNIA HSA	OTHER	Rx	DENTAL	SAPD
COVERAGE CODE c/o										
TOTAL APPLICATIONS SUBMITTED										
TRANSFER FROM GROUP # _____										
REFUSALS/WAIVERS LISTING ATTACHED (IF APPLICABLE)										
EMPLOYER CONTRIBUTION										
EFFECTIVE DATE										
FUTURE RATE RENEWAL DATE										

APPROVED BY: _____ _____

REVIEWER SIGNATURE DATE APPROVED

SECTION V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.) It is further understood that no agent has power on behalf of Horizon Blue Cross Blue Shield of New Jersey to make or modify any request or application for insurance or to bind Horizon Blue Cross Blue Shield of New Jersey by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Horizon Blue Cross Blue Shield of New Jersey. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

It is understood that I am responsible to provide Horizon Blue Cross Blue Shield of New Jersey with timely and accurate information regarding the date of hire for new employees and that the requested effective date of coverage will properly apply any orientation period and waiting period requirements applicable to my plan. It is further understood that any retroactive termination requests must be limited to those for which no premium or contribution has been paid for the termination period by the employee or dependent whose coverage is to be retroactively terminated.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at _____ on _____

_____ _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

_____

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification